

BEFORE THE
NATIONAL LABOR RELATIONS BOARD

In the Matter of:

CAYUGA MEDICAL CENTER AT ITHACA, NY,

Respondent,

-and-

1199 SEIU UNITED HEALTHCARE WORKERS
EAST,

Case Nos.: 03-CA-185233
03-CA-186047

Charging Party.

**MEMORANDUM OF LAW
ON BEHALF OF CHARGING PARTY
1199 SEIU UNITED HEALTHCARE WORKERS EAST**

Mimi C. Satter, Esq.
Patrick R. Blood, Esq.
SATTER LAW FIRM, PLLC
Attorneys for Union
217 S. Salina Street, 6th Fl
Syracuse, NY 13202
Tel.: (315) 471-0405
Fax: (315) 471-7849

TABLE OF CONTENTS

	PAGE
TABLE OF AUTHORITIES	iv
PRELIMINARY STATEMENT	1
STATEMENT OF FACTS	2
I. KEY PLAYERS	2
A. Cayuga Medical Center	2
B. Anne Marshall	2
C. Loran Lamb	3
D. Karen Ames	4
E. Debra Raupers	4
F. The Patient	5
G. Star York	5
H. Linda Crumb	6
I. Brian Forrest:	6
J. John Turner:	7
K. Jackie Barr	7
L. Scott Goldsmith	7
M. Dr. Daniel Sudilovsky	8
N. ICU Nurses	8
II. UNION ORGANIZING CAMPAIGN	9

III.	THE HOSPITAL'S BLOOD TRANSFUSION POLICY	11
A.	The Hospital's Blood Transfusion Policy As Written	11
B.	Transfusion Card	12
C.	The Hospital's Blood Transfusion Policy As Practiced In The ICU	13
IV.	SEPTEMBER 11 TRANSFUSION	19
V.	THE PATIENT COMPLAINT AND SUBSEQUENT INVESTIGATION	22
VIII.	NURSING PEER REVIEW COMMITTEE MEETINGS	27
IX.	THE TERMINATIONS OF MS. LAMB AND MS. MARSHALL	29
X.	DISPARATE TREATMENT OF MS. MARSHALL AND MS. LAMB	31
A.	The Comparator Evidence Reveals That CMC Implements Progressive Discipline, Even When Nurses Commit Egregious Errors	31
B.	CMC Presented No Evidence Indicating Discipline Issued For Events Resulting In Incident Reports	33
XI.	CMC'S PRETEXTUAL PLANNING	35
ARGUMENT		38
Point I:	The Employer Violated the Act When it Terminated Anne Marshall and Loran Lamb	38
A.	CMC Knew Ms. Marshall and Ms. Lamb Were Engaged In Protected Activity	40
i.	The Hospital Viewed Anne Marshall As The Union Campaign "Ringleader"	40
ii.	CMC Terminated Ms. Lamb Largely To Hide Discriminatory Conduct Against Ms. Marshall	42
B.	CMC Was Motivated By Anti-Union Animus	43

C.	CMC's Preferred Reasons For Discharge Are Pretext And/Or Substantially Unlawfully Motivated	47
i.	CMC Did Not Rely Upon The Alleged Policy Violations And Therefore Its Justifications For The Terminations Are Pretextual	47
ii.	To The Extent CMC Relied On Policy Violations, The Terminations Were The Result Of Mixed Motive	50
Point II:	CMC Violated the Act by Prohibiting Nurses from Posting Pro-Union Literature on the Bulletin Board	52
Point III:	CMC Violated §8(A)(1) of the Act When it Questioned Potential Employee Witnesses	53
CONCLUSION	54

TABLE OF AUTHORITIES

	PAGE
<i>800 River Rd. Operating Co. LLC v. NLRB</i> , 784 F.3d 902 (3 rd Cir. 2015)	38
<i>Active Industries</i> , 277 NLRB 376 (1985)	43
<i>Addicts Rehabilitation Center Fund, Inc.</i> , 330 NLRB 733 (2000)	50
<i>AdvoServ of New Jersey</i> , 363 NLRB No. 143 (2016)	51
<i>Affinity Medical Center</i> , 362 NLRB No. 78 (April 30, 2015)	44, 48
<i>Albertson's, LLC</i> 359 NLRB 1341 (2013)	53
<i>Alle-Kiski Medical Center</i> , 339 NLRB 361 (2003)	40
<i>Alliance Rubber Co.</i> , 286 NLRB 645 (1987)	43
<i>Amptech, Inc.</i> , 342 NLRB 1131 (2004)	50
<i>Carpenters' Health & Welfare Fund</i> , 327 NLRB 262 (1988)	43
<i>Columbia Mem. Hosp.</i> , 362 NLRB No. 154 (July 30, 2015)	43
<i>Consolidated Bus Transit, Inc.</i> , 350 NLRB 1064 (2007)	38, 39
<i>Davis Supermarkets</i> , 306 NLRB 426 (1992), enfd. 2 F.3d 1162 (D.C. Cir. 1993)	43
<i>Dawson Carbide Industries</i> , 273 NLRB 382 (1984), enfd. 782 F.2d 64 (6th Cir. 1986)	42
<i>Diamond Electric Mfg.</i> , 346 NLRB 857 (2006)	50
<i>Embassy Vacation Resorts</i> , 340 NLRB 846 (2003)	39, 42
<i>Golden State Foods Corp.</i> , 340 NLRB 382 (2003)	39, 49
<i>Greenbrier VMC, LLC</i> , 360 NLRB 994 (2014)	50
<i>Heartland of Lansing Nursing Home</i> , 307 NLRB 152 (1992)	43

<i>Honeywell, Inc.</i> , 262 NLRB 1402 (1982) enfd. 722 F.2d 405 (8th Cir. 1983)	52
<i>Johnnie's Poultry</i> , 146 NLRB 770 (1964), enf. denied 344 F.2d 617 (8th Cir. 1965)	53
<i>LaGloria Oil and Gas Co.</i> , 337 NLRB 1120 (2002)	47
<i>Limestone Apparel Corp.</i> , 255 NLRB 722 (1981), enfd. 705 F.2d 799 (6 th Cir. 1982)	39, 48
<i>NLRB v. Aluminum Casting & Eng'g Co.</i> , 230 F.3d 286 (2000)	38
<i>NLRB v. Baptist Hospital, Inc.</i> , 442 U.S. 773 (1979)	52
<i>NLRB v. Caval Tool Div., Chromalloy Gas Turbine Corp.</i> , 262 F.3d 184 (2d Cir. 2001)	40
<i>NLRB v. Frigid Storage, Inc.</i> , 934 F.2d 506 (4 th Cir. 1991)	43
<i>NLRB v. Great Dane Trailers, Inc.</i> , 388 U.S. 26 (1967)	38, 39
<i>NLRB v. Wright Line</i> , 662 F.2d 899 (1 st Cir. 1981), cert. denied 455 U.S. 989 (1982)	38
<i>North Carolina License Plate Agency #18</i> , 346 NLRB 293 (2006)	39
<i>Norton Audubon Hospital</i> , 341 NLRB 143 (2004)	44, 48
<i>Nursing Center at Vineland</i> , 314 NLRB 947 (1994)	44, 48
<i>Opportunity Homes, Inc.</i> , 315 NLRB 1210 (1994)	50
<i>Robert Orr/Sysco Food Services, LLC</i> , 343 NLRB 1183 (2004), enfd. 184 Fed. Appx. 476 (6 th Cir. 2006)	39, 40
<i>Royalite</i> , 324 NLRB 429 (1997)	44
<i>Somerset Valley Rehabilitation and Nursing Center</i> , 358 NLRB 1361 (2012), aff'd 825 F.3d 128 (3d Cir. 2016)	40
<i>Southside Hospital</i> , 344 NLRB 634 (2005)	48

<i>St. John's Community Svcs. - New Jersey</i> , 355 NLRB 414 (2010)	42
<i>St. Margaret Mercy Healthcare Centers</i> , 350 NLRB 203 (2007)	50, 52
<i>Standard-Coosa-Thatcher, Carpet Yarn Division</i> , 257 NLRB 304 (1981), enfd. 691 F.2d 1133 (4th Cir. 1982), cert. denied 460 U.S. 1083 (1983)	53
<i>Stark Electric, Inc.</i> , 324 NLRB 1207 (1997)	43
<i>Stoody Company, Div. Of Thermadyne, Inc.</i> , 312 NLRB 1175 (1993)	40
<i>Talawanda Springs, Inc.</i> , 280 NLRB 1353 (1986)	48
<i>United Refrigerated Svcs., Inc.</i> , 325 NLRB 258 (1998)	40
<i>Wal-Mart Stores</i> , 340 NLRB 703 (2003)	52
<i>Wright Line Div.</i> , 251 NLRB 1083 (1980), enfd. 662 F.2d 899 (1st Cir. 1981), cert. denied 455 U.S. 989 (1982)	38, 39, 47

PRELIMINARY STATEMENT

The matter before the Administrative Law Judge is a complaint issued by Region 3, National Labor Relations Board, alleging respondent Cayuga Medical Center ["CMC" or "Hospital"] violated §§8(a)(1) and (3) of the National Labor Relations Act ["the Act"] in the context of an organizing campaign by 1199 SEIU United Healthcare Workers East ["1199" or "Union"]. Specifically the complaint alleges CMC violated §§8(a)(1) and (3) when it terminated Registered Nurses Anne Marshall and Loran Lamb for engaging in protected, concerted activities; §8(a)(1) when it prohibited the posting of pro-union literature while permitting other literature in a non-patient care area; and §8(a)(1) in the context of questioning an employee about possible testimony in this proceeding.

Since 2015, registered nurses at CMC have sought to have 1199 designated as their collective bargaining representative. These efforts have been inhibited in no small part by unfair labor practices ["ULPs"] committed by CMC, including those substantiated in an October 28, 2016 decision issued after a ULP hearing presided over by Administrative Law Judge David I. Goldman ["ALJ Goldman"]. *Cayuga Medical Center at Ithaca, Inc., and 1199 SEIU United Healthcare Workers East, (03-CA-156375, 03-CA-159354, 03-CA-162848, 03-CA-165167, 03-CA-167194) ["Goldman Dec."]*.

In the matter at-bar, the parties presented evidence before Administrative Law Judge Kimberly Sorg-Graves on January 9-12, February 27-8, March 1-3, 6-10, and April 3-4, 2017 in Ithaca, New York. Additionally, ALJ Sorg-Graves took judicial notice of the entire record in the proceedings before ALJ Goldman. *Trial Transcript p.25 [hereinafter "Tr. p. -"]*.

STATEMENT OF FACTS

In an effort to give structure to a hearing spanning 16 days and resulting in well over 100 exhibits, the Union will identify key “players,” followed by a summary of relevant facts.

I. KEY PLAYERS:

A. Cayuga Medical Center: Respondent is a community hospital, providing acute care in Ithaca, New York; it employs approximately 1,350 employees, including 350 nurses, none of whom are unionized. *Goldman Dec.*, p. 2. About 30 nurses work in the Hospital’s intensive care unit [“ICU”], generally divided between 12-hour day and night shifts. *Goldman Dec.*, p. 2; *Tr. p. 3023*.

The Hospital has a documented history of union animus, directed against specific nurse organizers. *Goldman Dec.*, *passim*. This animus has manifest through, *inter alia*, the discriminatory removal of union literature and postings, personal threats, discipline and demotion of a key nurse organizer (*Goldman Dec.*, p. 57) and most recently the termination of two nurses. *See Tr. pp. 1183-5*.

B. Anne Marshall: Discriminatee Marshall was hired by CMC in 2007. *Tr. p. 1185; Goldman Dec.*, p. 38. Until her termination on October 6, 2016, she worked as a nurse in the ICU. *Tr. pp. 1183-5*. Acting as lead organizer for the 1199 campaign, frequently Ms. Marshall hosted meetings, posted information on CMC bulletin boards, distributed literature and tabled in the Hospital cafeteria. *Tr. pp. 1185-6*. By all measures, Ms. Marshall was a “vigorous and open supporter of the union drive.” *Goldman Dec.*, p. 46.

Prior to the organizing campaign, Ms. Marshall had “an unbroken record of superlative annual personnel reviews,” dating back to her hire. *Goldman Dec.*, p. 38. Ms. Marshall’s leadership skills were recognized in 2013, when the Hospital promoted her to Team Leader. *Goldman Dec.*, p. 38. Indeed, she had an “unblemished disciplinary record” until CMC suspended her unlawfully for engaging in protected concerted activity in 2015. *Goldman Dec.*, p. 38. Ultimately Ms. Marshall was cleared of wrongdoing and returned to work and organizing until her October 6, 2016 termination. *Tr. p. 1185; see generally, Goldman Dec.*

C. Loran Lamb: Discriminatee Lamb was hired by CMC in June, 2011, working primarily in the ICU, often with Ms. Marshall. *Tr. pp. 1525-6.* During the summer, 2015, CMC unlawfully invited employees to report and inform about union solicitations. *Goldman Dec.*, pp. 11-12. Despite this pressure, Ms. Lamb signed a union authorization card. *Tr. p. 1526.* Likewise, she participated openly in the 1199 drive, often wearing a pro-union “Rosie the Riveter” pin on her scrubs and tabling with Ms. Marshall in the cafeteria. *Tr. pp. 1186, 1526-9.* Relative to Ms. Lamb’s support, Ms. Marshall noted that it was particularly “nice” considering many employees were “afraid to stop and talk” or even associate with the Union. *Tr. p. 1187.*

The Hospital had knowledge of Ms. Lamb’s support for the union campaign prior to her termination. *See Tr. pp. 1526-7.* In 2015, Ms. Lamb was approached by ICU Director Joel Brown about the Union. *Tr. pp. 1526-8.* In a one-on-one meeting, with his office door shut, Director Brown, in a ‘very aggressive manner,’ explained the “negative things about having a union as a nurse.” *Tr. pp. 1527-8.* Nevertheless, Ms. Lamb persisted in her support for the Union, continuing to voice her concerns. *Tr. p. 1528.* Ms. Lamb had never been disciplined prior to

being terminated for her role in assisting Ms. Marshall with a blood transfusion on September 11, 2016. *See Tr. pp. 1525, 1542-3, 1565.*

D. Karen Ames: Ms. Ames is the Chief Patient Safety Officer and Director of Quality and Patient Safety. *Tr. p. 757.* Despite not being a registered nurse, the Hospital charged her with reviewing and investigating Ms. Marshall and Ms. Lamb's alleged violations of CMC's blood transfusion policy. *Tr. pp. 757-8.* Ms. Ames essentially "wrapped up" and completed her investigation before speaking to discriminatee Marshall. *Tr. pp. 3302, 3360-1.* While Ms. Ames eventually discussed the transfusion with Ms. Marshall, it was in the context of imposing a suspension and ultimately termination. *Tr. pp. 3302, 3360-1.* At trial, Ms. Ames testified both as a 611(c)(2) witness, called by the General Counsel, and as a Hospital witness. *Tr. pp. 756, 3161.* When called by CMC, Ms. Ames displayed a markedly enhanced ability to recollect critical facts of her investigation, particularly as compared to her testimony as a 611(c)(2) witness. *See e.g., Tr. pp. 763-5; cf. 3395.*

E. Debra Raupers:¹ Since joining the Hospital in October, 2015, Ms. Raupers has been its Vice President of Patient Services and Chief Nursing Officer. *Tr. p. 3437.* A registered nurse for 32 years, she was quite proud of her many and varied achievements, including "[a] lot of awards for leadership in nursing." *Tr. pp. 3438-9.* Among her achievements is "an exceptional job dealing with the labor organizing threats" faced by CMC, as well as handling herself "in a professional manner in some trying circumstances," including "the issue of the blood

¹As respondent's party representative, Ms. Raupers was present during the entire hearing. She testified last for CMC, after nearly 30 witnesses called by the General Counsel and Hospital. As a practical matter, she was the only witness not covered by the sequestration order.

transfusion.”² *Tr. pp. 3604-06*. Ms. Raupers was the “ultimate decision maker” regarding the terminations of Ms. Marshall and Ms. Lamb. *Tr. pp. 1008, 3361*.

F. The Patient: The Patient did not testify, despite CMC’s early indication that she would be called.³ *See Tr. p. 443*. The Patient has a condition that requires blood transfusions. *Tr. p. 461*. While at CMC, she had a very low white blood count and was “septic,” necessitating staff and visitors use neutropenic precautions. *Id.* Thus, those in close proximity to the Patient were required to wear a mask and gloves. *Id.* The Patient’s account of the September 11 transfusion enabled the Hospital to assert a pretextual basis for terminating Ms. Marshall and Ms. Lamb, while ignoring entirely her other concerns and complaints regarding the inconsistent use of neutropenic precautions, lack of green caps on lines, failure to call in an essential, post discharge script, etc. *See Tr. pp. 462-4,880-1,3392; Exhs. GC 18, E 6*.

G. Star York: The Patient’s sister, Star York, visited her at CMC between September 8 and 13. *Tr. pp. 483-4*. Ms. York resides in Maine, where she is a critical care nurse. *Tr. p. 423*. Ms. York is not licensed as a registered nurse in New York. *Tr. pp. 489-90*. In her employment, often Ms. York administers blood products, albeit pursuant to her employer’s own policy and Maine regulations. *Tr. pp. 424, 489-90*.

²Curiously, Ms. Raupers claimed not to recall this statement in her annual performance review by Hospital CEO John Rudd, despite that it factored into her annual bonus. *Tr. P. 3606*.

³At the commencement of trial, CMC sought to call the Patient out of order, either via video conferencing or having the ALJ, court reporter and counsel travel to Buffalo where she was in treatment. *See Tr. pp. 475-7*. Understandably, counsel did not want to go out of order, nor take testimony remotely, unless absolutely essential. Based on the representation that the Patient would be in Ithaca by February 23, the parties agreed to defer. *See Tr. p. 3228*. By the time the Hospital tried to call the Patient toward the end of its case, her health had deteriorated, such that she could not be called. *See Tr. pp. 3224-31*.

H. Linda Crumb: Ms. Crumb is a registered nurse, first hired by CMC in 1974. *Tr. p. 3020-01.* Since 2007 she has served as Assistant Vice President For Patient Services. *Id.* Ms. Crumb's duties include managing day-to-day operations of CMC nursing. *Tr. p. 3020.* She reports directly to Ms. Raupers. *Id.*

Ms. Crumb played a significant role in the unlawful, July 2015 suspension of Anne Marshall. *See Goldman Dec., pp. 42-54.* ALJ Goldman noted several discrepancies in her testimony regarding her investigation, including the consistent reliance on "documents" and "leading questioning." *Goldman Dec., p. 53.* In July, 2016, Ms. Crumb became interim director of the ICU, a position she held until September 13, 2016. *Tr. p. 3022.* Notably, the incident relied upon to justify the termination of Ms. Marshall and Ms. Lamb occurred during her brief tenure as ICU director.

I. Brian Forrest:⁴ Mr. Forrest is the Vice President of Human Resources, responsible for, *inter alia*, overseeing CMC's hiring and firing policies. *Tr. p. 1007.* He provided advice and guidance to Ms. Raupers, although she made the ultimate termination decisions. *Tr. p. 1008.* Mr. Forrest prepared CMC's "Next Steps for Response to Union" after ALJ Goldman's decision in October, 2016. *Tr. pp. 1019-20; Exhs. GC 23, 24.* He made his sentiments toward the decision clear, calling it "corrupt and unfair" and promising "to keep pressing on to seek to get this into an honest and fair setting and do the best damage control we can in the meantime." *Tr. p. 1017; Exh. GC 23.*

⁴Mr. Forrest was called by the General Counsel as a Rule 611(c) witness.

J. John Turner:⁵ Mr. Turner is CMC's Public Relations Specialist and reports to CEO John Rudd. *Tr. pp. 875-7*. His duties include communications, marketing and patient relations. *Tr. pp. 875-6*. Despite having no medical background, Mr. Turner was tasked with responding to the Patient and her sister regarding their various concerns. *See Tr. pp. 875-6, 883*. Mr. Turner attributed all their complaints to Ms. Marshall's nursing care, contrary to Ms. York's express testimony otherwise. *Tr. 881-3; cf. Tr. pp. 460-3*. Mr. Turner's testimony revealed clearly that CMC paid no attention to the numerous concerns unrelated to Ms. Marshall and Ms. Lamb, focusing instead on a fortuitous opportunity to remove two vocal union supporters.

K. Jackie Barr: Ms. Barr works under Mr. Turner, handling patient comments and complaints.⁶ *Tr. p. 876*. In July, 2016, she removed Ms. Marshall's postings regarding a union meeting from a CMC bulletin board. *Tr. p. 1187*. She admonished Ms. Marshall, "the bulletin board is not for things like that." *Tr. p. 1188*. Notwithstanding, Ms. Barr left postings on the bulletin board relating to the Jehovah's Witness, salsa dancing and a lake swim. *Tr. 1189*.

L. Scott Goldsmith: Mr. Goldsmith was the charge nurse in the ICU on September 11, 2016, the day of the at-issue transfusion. *See Tr. pp. 2932-4*. The Patient complained to Mr. Goldsmith, who spoke separately with Ms. Marshall and Ms. Lamb. *Tr. p. 2932*. He did not file

⁵Mr. Turner, too, was a Rule 611(c) witness.

⁶It is telling that patient complaints fall within CMC's Public Relations Department.

a QA⁷ until two days later and did not mention the incident to ICU Interim Director Crumb until the next day when he happened to run into her in the hall.⁸ *Tr. pp. 2942-4, 2970.*

M. Dr. Daniel Sudilovsky: Chair of Pathology Laboratory Medicine and the Director of Laboratories at CMC, Dr. Sudilovsky is “essentially responsible for anything that falls under the umbrella of the laboratory.” *Tr. pp. 1832, 1836.* He “edited, signed and condoned” the Hospital’s current blood transfusion policy. *Tr. p. 1889.* Although testifying initially that he would not allow Ms. Marshall or Ms. Lamb to administer blood products at CMC, when questioned about whether his opinion would change, if he knew that Ms. Marshall checked the Patient’s wristband, as she did, his position softened considerably. *Tr. pp. 1966-71.*

N. ICU Nurses: Joan Tregaskis, Ananda Szerman, Anita Tourville-Knapp, Mary Day and Christine Monacelli are ICU nurses who were called by the General Counsel to testify relative to their practices in administering blood. Additionally Tregaskis, Szerman and Tourville-Knapp testified about their interactions with Ms. Ames in her so-called investigation regarding the reality of blood administration in the ICU. *See Tr. pp. 65-307; 338-422; 527-748; 911-1005; 1079-1149; 1703-61.*

⁷A “QA” refers to an electronic reporting system that allows CMC staff members to report incidents relating to “quality assurance.” *Tr. pp. 314-5, 335-7.*

⁸This suggests, certainly, that Mr. Goldsmith did not consider the actions of Ms. Marshall and Ms. Lamb to be inconsistent with ICU practices nor worthy of immediate action.

In forthright⁹ and credible testimony, the ICU nurses described how common it is for the two-nurse check to happen only at the desk and for a single nurse to enter the patient room. As the ICU nurses testified, this reflects the overwhelming demands in the unit, the need to see the monitors located outside patient rooms, their confidence that the nurse entering the room will do a complete check and the culture in the unit. *See Tr. pp. 65-307; 338-422; 527-748; 911-1005; 1079-1149; 1703-61.* Overall, their testimony confirmed that the actions of Ms. Marshall and Ms. Lamb on September 11, 2016 were consistent with common practices in the ICU.

II. UNION ORGANIZING CAMPAIGN

Pro-union literature first began appearing at CMC in or around March, 2015. *Goldman Dec., p. 10.* It addressed the growing frustration of the registered nurses over wages, staffing shortages and safety concerns. *Id.* By no later than April, 2015, it was clear that Ms. Marshall was the source of the pro-union postings appearing throughout the Hospital. *Goldman Dec., p. 38.* CMC management responded with “information and argument to employees against unionization,” including that anyone “being harassed or intimidated” by the Union should contact a “supervisor, director or security.” *Goldman Dec., p. 10.* By May, 2015, the Hospital was more overt in its opposition to the union campaign, dispatching to all 350 nursing staff a series of letters and emails, largely consisting of arguments against unionization. *Id.*

⁹Given that Ms. Marshall and Ms. Lamb were summarily terminated for not doing a two nurse, bedside check, one cannot overstate the courage it took these nurses to admit they have done the same on a regular basis.

Nonetheless, the nurses continued campaigning for union representation. *See, Goldman Dec., p. 28.* In late-June, 2015, CMC responded forcefully, suspending Ms. Marshall for “disrespect,” alleging her discussions with management over working conditions violated the Nursing Code of Conduct. *Goldman Dec., p. 49.* CMC clamped down further, prohibiting Ms. Marshall from distributing Union literature in the cafeteria while on non-working time (*Goldman Dec., p. 55*) and telling employees that it was inappropriate to discuss certain working conditions. *Goldman Dec., p. 15.*

1199 filed unfair labor practices charges, resulting in issuance of Complaint and a hearing on May 2-6 and 24, 2016 before ALJ Goldman. *Goldman Dec., p. 2.* Even while the action was pending, Ms. Marshall persisted in her role as lead organizer, wearing “pro-union buttons every shift that she worked.” *Tr. pp. 1528, 1185-6.* In July, 2016, she posted a notice of an upcoming Union organizing meeting on a CMC bulletin board where other non-work related materials were posted.¹⁰ *Tr. p. 1187.* Immediately, Ms. Marshall was confronted by CMC staff member Jackie Barr, who removed the notice, admonishing “the bulletin board is not for things like that.” *Tr. p. 1188.* Ms. Marshall and Ms. Lamb continued their organizing efforts until their eventual termination for the September 11 transfusion that gave rise to the matter at-bar.

¹⁰This is the same bulletin board that earlier CMC had prohibited employees from using for distributing and posting union literature and which was a subject of the prior ULP Complaint. *Goldman Dec., pp. 20-2.*

III. THE HOSPITAL'S BLOOD TRANSFUSION POLICY

A. The Hospital's Blood Transfusion Policy As Written

Over the past several years, CMC has issued multiple versions of its blood transfusion policy. *Tr. p. 1872*. Indeed, Dr. Daniel Sudilovsky, the policy's editor, called the revisions "an ongoing refinement" and characterized the policy generally as a "living document." *Id.* Making matters more complicated, the Hospital maintains an intranet database, containing well over 100 distinct policies. *Tr. p. 1157*. Nurses are prohibited from printing these policies; thus, obtaining copies of the most up-to-date procedure can be quite trying. *Id.*

Prior to September 11, 2016,¹¹ Section 12 of CMC's transfusion policy included, in pertinent part, a "two-tier, two-nurse verification." *Tr. p. 3444; Exh. GC 3, p. 5*. Section 12.A requires that nurses, before taking the blood into the patient room, verify the blood against the order and chart for the correct information, including name, blood type, type of blood product, order and consent. *Exh. GC 3, p. 5*. This policy states clearly, "[n]o product should enter the patient room until it is verified." *Id.* (emphasis supplied). Section 12.B addresses what happens inside the room: "verification must occur matching the blood to the patient with two identifiers (name, date of birth [DOB]); verbally and against the patient wrist band." *Id.* Section 12.C mandates that the blood "must not be hung before verification has occurred." *Id.* Finally, the policy states, "[i]f the nurse is interrupted for something more pressing, the incoming nurse will need to re-verify that the product is correct before transfusing." *Id.*

¹¹Testament to the procedure's impermanence as written, the policy was changed at least twice after the September 11 transfusion and conclusion of the hearing. *See Exhs. GC 60 and 61.*

Section 13 speaks to the “2-RN bedside checklist.” *Exh. GC 3, p.5*. The checklist requires verifications for the provider’s order and the patient’s signed consent. *Id.* The list includes checks for the blood bag number, expiration date, blood type and Rh. *Id.* The text indicates that two nurses identify the patient at the bedside by asking the patient for his/her name and date of birth. *Exh. GC 3, p.6*. This is then compared to the patient’s wrist band and blood transfusion card. *Exh. GC 3, p.5*. The policy does not state what happens if a patient cannot be asked because s/he is sedated or unconscious; nor does it speak to the physical location wherein the blood transfusion card should be completed. *See generally Exh. GC 3*.

B. Transfusion Card

Each blood unit is accompanied by a card¹² that serves as a record of the transfusion. *Tr. pp. 3455-6; see Exh. GC 2*. The blood card contains at least six boxes that must be initialed by the nurses, including the checklists referenced in Sections 12 and 13 of the policy. *See Exh. GC 2; Tr. p. 3456*. The top two boxes state “physician order verified” and “informed consent has been obtained.” *Id.; Tr. p. 1235-6*. Below this are four boxes, confirming patient name and date of birth, “unit is not outdated,” “unit type” and date and time when the transfusion starts. *Id.; Tr. p. 1236-7*.

Curiously, there is a line between the top two boxes and remaining four, stating “Below information must be verified at Patient Bedside.” *See Exh. GC 2*. This appears inconsistent with Section 12.A’s instruction “*before taking the blood into the patient room, verify the blood against the order and chart for the correct information, including name, blood type, type of blood*

¹²This document is called a “blood card,” “transfusion card” or “tag,” seemingly interchangeably.

product, order and consent.” *Exh. GC 3, p. 5* (emphasis supplied). At the hearing, Dr. Sudilovsky acknowledged the inconsistencies in the procedure, testifying,

...[nurses] can check it in both places, fine. The policy says check it outside the room. This box says check it in the room, that may be an inconsistency. But, the policy is what comes to everything.”

*Tr. p. 1965.*¹³

C. The Hospital’s Blood Transfusion Policy As Practiced In The ICU

ICU nurses testified that the database containing the policy is “very hard to navigate and difficult to find policies on.” *Tr. p. 1157*. Adding to the difficulty, nurses are not allowed to print policies as they can change “day to day.” *Id.* CMC management has responded to inquiries on the matter by saying “they would look into addressing that.” *Tr. p. 1158*. As a result, nurses rely on their experience, training and departmental practices in giving blood transfusions. *See Tr. p. 165*. General Counsel witnesses Mary Day, Chrissy Monacelli, Joan Tregaskis, Anita Tourville-Knapp and Ananda Szerman are all registered nurses in the ICU; each testified to her practice and experience in performing blood transfusions. *See Tr. pp. 65-307; 338-422; 527-748; 911-1005; 1079-1149; 1703-61*.

Ms. Day was hired by CMC in 1999 and has spent approximately 14 years in the ICU. *Tr. pp. 66-7*. First to testify, she outlined the entire blood transfusion process from start to finish. *See Tr. p. 67-75*. The process begins when a physician determines one or more units of blood are needed. *Tr. p. 67*. The physician writes an order, which is conveyed electronically to the blood

¹³Strikingly, the policy’s editor acknowledges the blatant discrepancy, yet nonetheless, CMC management charged Ms. Marshall and Ms. Lamb with “falsifying records” for completing the card in a manner practiced frequently by veteran ICU nurses.

bank. *Tr. pp. 67-8.* Thereafter, a courier is dispatched to retrieve the unit(s). *Id.* At the blood bank, the courier and a blood bank technician review the order sheet, ensuring the correct patient name, date of birth, account number, blood type and donor number. *Tr. p. 68.* Additionally, they check for anything unusual about the blood unit(s), e.g., expiration, leaks, appearance. *Id.* When complete, the courier signs a verification and release slip and takes the blood to the floor. *Id.*

Upon arrival, the courier delivers the blood and accompanying documentation to the nurse designated to complete the transfusion ["Primary Nurse"], who then signs for the blood at the ICU charge nurse desk. *Tr. p. 70.* At this point, the Primary Nurse "takes the lead," seeking assistance from another nurse ["Secondary Nurse"]. *Tr. pp. 69-72.*

Whether the Secondary Nurse physically enters the patient room often "depends on what else is going on in the ICU." *Tr. p. 72.* Although admittedly the transfusion policy applies to the entire Hospital, the ICU has its own practices, reflecting the many demands on the nurses caring for CMC's "sickest patients" who are often "unstable." *Id.* While each ICU patient has a monitor outside his/her room, there are no "monitor techs;" thus it falls on nurses to monitor patients, despite that often there is "no other soul in the ICU corridor." *Id.* By way of example, Ms. Day testified, "if I know a patient has been unstable...I might be reluctant to truly go in the room with the Primary Nurse." *Tr. p. 73.*

Chrissy Monacelli has worked as a registered nurse at CMC for 16 years. *Tr. p. 339.* She testified that the physical layout of the unit is "rather large," adding that it is "frequently understaffed." *Tr. p. 345.* Based on her considerable experience, Ms. Monacelli testified:

[Y]ou need to think about all of the patients' safety versus taking two RN's to go into that patient receiving a blood transfusion's room because there aren't often

not [sic] enough nurses on the floor and therefore, if two are in there, there often can be no one out watching the other monitors—watching the monitoring systems, listening for other patients’ alarms and that sort of thing. So we frequently – you know – I think that nurses felt uncomfortable stepping away from that situation or even their own charting, as we’re constantly on a time crunch. *Tr. pp. 345-6.*

Ms. Monacelli has observed personally several ICU nurses perform the two-step verification at the desk without both entering the patient room. *Tr. pp. 690-1.* Ms. Monacelli identified Anne Marshall, Loran Lamb, Mary Anne Gnatt, Sarah Bulthius, Kristy Lychalk, Jennifer Easter, Mary Day, Joan Tregaskis, Anita Tourville-Knapp and Andrew Barnes as nurses who she has seen “do a desk check and not do a bedside check.” *Tr. p. 691.* Ms. Monacelli recalled that on several occasions, even the former ICU director, Shawn Newvine, when acting as her Secondary Nurse, did not follow her into the patient room.¹⁴ *Tr. p. 679.*

Anita Tourville-Knapp has worked in the CMC ICU since August, 2007. *Tr. p. 1703.* In September 2016, Karen Ames approached Ms. Tourville-Knapp with a transfusion card, asking if she “followed the policy?” *Tr. p. 1705.* Ms. Tourville-Knapp responded that she did, clarifying “although it isn’t always followed exactly.” *Id.* She added,

sometimes it’s really difficult to find a nurse. But we would find the first one we could. I’ve actually had nurses refuse to check blood with me because they were just too busy. In general, I told her it’s when...we may be watching another patient.

¹⁴To the extent Mr. Newvine’s testimony was to the contrary, it should be discredited. Multiple nurses, including Ms. Monacelli, testified extremely credibly that Mr. Newvine did not always enter the patient’s room with them. *See Tr. p. 679.* In so doing, these nurses put their futures at CMC at risk. Their willingness to do so, as well as the number of nurses who testified consistently must weigh heavily against the credence accorded Mr. Newvine.

Id. Notably, at the time of Ms. Ames's questioning, Ms. Tourville-Knapp was unaware of the September 11 blood transfusion incident with Ms. Lamb and Ms. Marshall.¹⁵ *Tr. p. 1706.*

Ms. Tourville-Knapp also spoke to her experience completing transfusion cards. *Tr. p. 1709.* When asked by General Counsel whether her practice relative to filling out the blood card changes with regard to bedside checks, Ms. Tourville-Knapp responded unequivocally "It hasn't changed." *Id.* In other words, in her experience, regardless of whether the Secondary Nurse enters the room, the blood transfusion card is completed in the same manner as if both nurses had entered. *Id.*

Joan Tregaskis is the most senior registered nurse to testify, having worked in the ICU for approximately 30 years. *Tr. p. 912.* Ms. Tregaskis testified candidly that a second nurse cannot always be in the room "100% of the time." *Tr. p. 923.* When asked why, Ms. Tregaskis responded "staffing; busy; patient safety; and other respects." *Tr. p. 924.* Ms. Tregaskis testified also that on at least one occasion, Shawn Newvine acted as her Secondary Nurse.¹⁶ *Tr. p. 927.* On this particular occasion, they checked the blood together at the desk before she, alone, entered the patient's room to complete the final bedside verification and hang the blood. *Id.* Ms. Tregaskis also recounted checking blood as Secondary Nurse with Chrissy Monacelli. *Tr. p. 935.* During these instances, she did not enter the room. *Tr. pp. 934-5.* Ms. Tregaskis also recalled checking blood outside a patient's room with Ms. Marshall. *Tr. p. 944.*

¹⁵Consequently, there can be no credible argument that her response to Ms. Ames was an attempt to help her friends, as she did not know they were in need of help. Indeed, any such argument by CMC should be rejected.

¹⁶*See footnote 14, supra.*

Ms. Ames questioned Ms. Tregaskis about the Hospital's blood transfusion protocol shortly after the September 11 transfusion. *Tr. p. 913*. Ms. Tregaskis related that she checks the blood in the patient room; however, she also told Ms. Ames that "there are times when it's really crazy and it just can't be checked in the room." *Tr. p. 913*. Ms. Tregaskis mentioned to fellow ICU nurse Anita Tourville-Knapp what she said and that the conversation with Ms. Ames "just made me nervous." *Tr. p. 915*. Contrary to Ms. Ames's summary email of their conversation, Ms. Tregaskis did *not* say she "always" checks the blood with another nurse at the bedside. *See Tr. pp. 978-81; cf. Exh. E 9*.

Ananda Szerman is a registered nurse, working currently at both CMC and Planned Parenthood of the Southern Finger Lakes. *Tr. p. 1080*. In November 2016, she transitioned from a full-time CMC employee to a part-time, per diem status. *Id.* Ms. Szerman made this change shortly after Ms. Marshall and Ms. Lamb were terminated, testifying, "I just felt like I needed to change my situation." *Id.* Ms. Szerman has worked in CMC departments other than the ICU. *Tr. p. 1112*. She noted that performing the bedside check in the ICU is significantly different from other areas in the Hospital. *Id.* On floors other than the ICU, patients cannot be seen from the nurse's station; however, in the ICU patients are in glass rooms, which can be seen from the nurses' desk. *Id.*

Similar to Ms. Tregaskis and Ms. Tourville-Knapp, Ms. Ames approached Ms. Szerman in September, 2016 regarding her practice relative to hanging blood. *Tr. pp. 1081-2*. Ms. Ames asked repeatedly, "so you hang blood with two nurses at the bedside?" *Tr. p. 1082*. First, Ms. Szerman responded, "well, I did today because they reminded us to do it with two nurses at the

bedside [at the morning safety meeting], but normally I [don't] always do it that way." *Id.* After Ms. Ames asked the same question again, Ms. Szerman responded just as clearly "not always, but I had been today because they told us at safety." *Tr. p. 1082.* Ms. Szerman testified that Ms. Ames continued to ask her the same thing, "probably three or four times." *Tr. pp. 1082-3.* Finally, "annoyed," Ms. Szerman said to Ms. Ames, "Message received," and went back to patient care. *Tr. p. 1083.*

CMC called four ICU nurses who testified in brief succession. *See Tr. pp. 2760-2826.* Laurel Rothermel has been with CMC since 2009 and currently works per diem. *Tr. pp. 2760, 2764.* She testified that she has performed 15 blood transfusions and has "never done it differently." *Tr. p. 2765.* She could not recall how many nurses with whom she has completed a blood product administration, and could name only two. *Tr. p. 2766.*

Andrew Barnes was hired by the Hospital in June, 2016 as a graduate nurse, roughly three months prior to the September 11 transfusion. *Tr. pp. 2776-7.* Mr. Barnes did not testify as to how many transfusions he has had involvement and, much like his experience as an ICU nurse, his testimony was limited. *See Tr. pp. 2776-96.*

Like Mr. Barnes, Katherine Race is a relatively recent hire. *Tr. p. 2826.* At the time of the September 11 transfusion, she had worked in the ICU for a little over a year. *Id.* She estimated being involved in approximately 10-20¹⁷ transfusions. *Tr. p. 2832.* None of the nurses she identified as having previously completed transfusions with her testified at trial. *See Tr. pp. 2835-6.*

¹⁷Given the wide discrepancy between 10 and 20, her memory and/or credibility are subject to question.

Jennifer Cole worked nights in the ICU from 2009 to February, 2017. *Tr. p. 2794.* She admitted that she has never performed a blood transfusion on the day shift. *Tr. p. 2808.* Ms. Cole identified several nurses she performed blood transfusions with in the past; however, she could not remember “specific patients or dates or anything like that.”¹⁸ *Tr. pp. 2808-13.*

Finally, Shawn Newvine worked at CMC from April, 2003 to April, 2015. *Tr. p. 2459.* During this tenure, he served as the Director of the ICU and Respiratory Therapy departments. *Tr. p. 2460.* Currently he works as Manager of Surgical Services at Chenango Memorial Hospital in Norwich, New York. *Tr. pp. 2458-9.*

Mr. Newvine said that while working in the CMC ICU he would be involved with the actual administration of blood product as a Secondary Nurse on “a fairly regular basis.” *Tr. pp. 2467-8.* He claimed that he always entered the room as the Secondary Nurse. *Tr. pp. 2471-2.* To the contrary, however, nurses Day, Monacelli and Tregaskis all testified that they had previously hung blood with Mr. Newvine and that he did not perform the two-nurse bedside check. *See Tr. pp. 101-2, 679, 927.* To the extent his statement contradicts the testimony of nurses Monacelli, Tregaskis and Day, it should be discredited.

IV. SEPTEMBER 11 TRANSFUSION

CMC’s claimed justification for terminating Ms. Marshall and Ms. Lamb involved a blood transfusion performed by both nurses on September 11, 2016. *See Tr. pp. 1244-7.* To be absolutely clear, on the day in question the Patient needed blood, she got blood and she received

¹⁸On cross examination of the ICU nurses called by General Counsel, counsel for the Hospital paid considerable attention to their inability to remember precise details of all prior transfusions. It turns out that the nurses called by CMC were no better in this regard. Given the rapid paced demands of the ICU, nurses did their jobs, without memorizing each minute detail.

the correct blood. *Tr. p. 1242*. She suffered absolutely no adverse health consequences as a result of the transfusion. *Id.* Moreover, during the Patient's stay at CMC, there were other documented violations, e.g., staff not taking the necessary neutropenic precautions, failure to use green caps on central lines and failure to call in a post discharge script. *Tr. pp. 880-1*. There is *no* evidence of any adverse action against staff involved in the other violations.

Turning to September 11, Ms. Marshall, acting as a Primary Nurse, received a physician order indicating one of her patients needed a blood transfusion. *Tr. p. 1224*. The order prompted Ms. Marshall to complete a four-part electronic form, with one section for the Patient's chart and another delivered to the downstairs blood bank. *Id.* Shortly after notifying the blood bank, Ms. Marshall received a call, stating the blood was ready for pickup. *Tr. p. 1225*. Thereafter, Ms. Marshall sent a courier to retrieve the blood. *Id.* This was the only ICU patient receiving blood on September 11. *Tr. p. 1546*.

While waiting for the blood, Ms. Marshall entered the room to pre-medicate the Patient, administering Benadryl and Tylenol orally. *Tr. pp. 1227-8*. As a part of this process, Ms. Marshall scanned both the medication and the Patient's wrist bracelet, in addition to verbally asking the Patient for her name and date of birth, verifying same. *Tr. p. 1228*. When the blood unit arrived, Ms. Marshall approached her charge nurse, Scott Goldsmith, asking if he would be her Secondary Nurse. *Tr. p. 1225*. Mr. Goldsmith conveyed he was unavailable and instructed her to check the blood with Ms. Lamb. *Id.* At this juncture, Ms. Marshall took the blood and the chart to Ms. Lamb, asking if she could act as Secondary Nurse. *Id.* Ms. Lamb agreed. *Id.*

Both nurses sat down at the nurse desk with the Patient's chart and the blood. *Tr. p. 1226.* Despite being unavailable to act as Secondary Nurse, Mr. Goldsmith stood approximately five to six feet behind the two nurses, in front of the unit's assignment board, while Ms. Marshall and Ms. Lamb verified the blood at the desk. *Id.* Ms. Marshall and Ms. Lamb verified the right patient, the right blood and the correct order and patient consent, before checking the Patient's identifiers, including her name, date of birth and account number. *Id.* Next, they examined the blood itself, identifying the donor, donor number, type and expiration date. *Tr. pp. 1226-7.*

After completing the verification, Ms. Marshall entered the Patient's room with the blood.¹⁹ *Tr. p. 1227.* Ms. Marshall approached the Patient and explained that the blood was ready to be hung. *Id.* Ms. Marshall primed the transfusion tubing before asking the Patient her name and date of birth, as well as confirming same on her wrist band.²⁰ *Tr. pp. 1228, 1238.* Because the Patient was under neutropenic precautions, Ms. Marshall wore scrubs, a mask and gloves. *Tr. p. 1228.*

Throughout the transfusion process, Ms. Marshall conversed with the Patient. *Tr. pp. 1228-9.* Although several family members were also present, Ms. Marshall spoke only to the Patient. *Id.* While hanging the blood, the Patient asked if Ms. Marshall had checked the blood, to which Ms. Marshall replied, "I have absolutely checked the blood and I have checked it out at the

¹⁹Notably, Charge Nurse Goldsmith, remained at the board near the nurses' desk, saying nothing about Ms. Marshall entering the room alone. *Tr. p. 1227.*

²⁰Nurses were able to scan a patient's wristband, before giving a medication; however, the CMC system is not set up to scan the wristband before administering a transfusion. *Tr. p. 369.* Query: If CMC has such serious concerns about transfusions, why would it not get a system that scans the wristband?

nurse's station with another nurse." *Tr. p. 1229*. Ms. Marshall hung the blood and ensured it was running and that the IV had no issues. *Id.* Her conversation with the Patient continued without any further mention of the blood. *Id.*

Satisfied that there were no issues with the transfusion, Ms. Marshall left the room, returning to the desk where she set the monitor to take the Patient's vital signs in 15 minutes. *Tr. pp. 1229-30*. Approximately five minutes later, Ms. Marshall returned briefly to the room to visually observe the Patient, who displayed no problems, nor did the Patient or her family express any concerns regarding the transfusion. *Tr. p. 1232*. After the 15-minute monitoring period, Ms. Marshall asked a nurse's aid to check the Patient's temperature. *Tr. p. 1231*. Meanwhile, the Patient's blood pressure, heart and respiration rates showed up on the monitor outside the room. *Tr. p. 1232*. The transfusion ended at 6:15 pm, with no indication of an adverse reaction and no comment to Ms. Marshall by the Patient or her family. *Exh. GC 2; Tr. p. 1233*.

V. THE PATIENT COMPLAINT AND SUBSEQUENT INVESTIGATION

At some point while receiving the transfusion, the Patient "waved" to Charge Nurse Goldsmith, who was just outside the room. *Tr. p. 2968*. When Mr. Goldsmith entered, the Patient conveyed that she had not been comfortable with the blood transfusion, whereupon he checked the blood and assured her it was correct. *Tr. pp. 444, 2968*. Notably the Patient did not request a reassignment and Ms. Marshall continued caring for the Patient for the remainder of the shift, without further incident nor expression of concern. *Tr. p. 2968*.

Later in the shift, Mr. Goldsmith spoke separately with both Ms. Lamb and Ms. Marshall. *Tr. p. 1548.* At trial, Mr. Goldsmith could not recall the exact dialogue of his discussions with either regarding the Patient's complaint. *Tr. pp. 2974-5.* Ms. Lamb recalled that after he spoke with Ms. Marshall, Mr. Goldsmith approached her about the Patient's complaint and the transfusion procedure. *Tr. p. 1548.* During that discussion, he did not mention anything about filing an incident report nor about discipline. *Tr. p. 1549.*

Mr. Goldsmith returned to his duties and completed the remainder of his shift. *Tr. p. 2968.* He did not write an incident report, discuss the complaint with ICU Interim Director Crumb, or anyone else in administration. *Tr. pp. 2968-9.* The next day, Mr. Goldsmith ran into Interim Director Crumb in the ICU hallway while on a break. *Tr. p. 2970.* For the first time, he mentioned the Patient's complaint. *Tr. p. 2970.* Although at trial Mr. Goldsmith claimed he intended to file an incident report before speaking with Interim Director Crumb, no report was filed or even drafted until after he told her the incident involved Ms. Marshall and Ms. Lamb and then at her express direction. *Tr. pp. 2968-71, 3052.* In fact, he did not submit the report until September 13, two days after the transfusion, and after Interim Director Crumb started an investigation. *Tr. pp. 3450-1.* Notably, when he finally submitted the report, he categorized the incident's severity level as zero. *Exh. E-4; Tr. p. 2973.*

After Mr. Goldsmith spoke with her, Interim Director Crumb spoke with CMC Vice President of Patient Services and Chief Nursing Officer Raupers. *Tr. pp. 3053, 3437.* Ms. Raupers, in turn, directed Ms. Crumb to speak with Chief Patient Safety Officer Ames, who

would oversee the investigation.²¹ *Tr. p. 3054*. Ms. Ames is not a registered nurse and while responsible for reviewing and investigating incident reports filed in the Hospital's system, she displayed an astonishing lack of knowledge regarding the underlying medical and safety concerns at issue therein. *Tr. pp. 757-8, 775-80*.

Ms. Ames had the opportunity to testify twice, first as a 611(c)(2) witness called by the General Counsel and secondly for CMC. On the first day, she displayed extraordinary terseness, resorting repeatedly to, "I couldn't answer that," "I don't know," and an indecisive combination of "I couldn't - - I don't know." *See Tr. pp. 756-71*. Seemingly, she could not resist this, even with the most straightforward questioning, such as when General Counsel asked:

GENERAL COUNSEL: In fact, two peer review committees were convened, weren't there?"

MS. AMES: I don't know

GENERAL COUNSEL: Was there a peer review committee on September 19th 2016?

MS. AMES: I don't recall the exact date, but I know there was one.

GENERAL COUNSEL: Were there one or two?

MS. AMES: I couldn't - - I don't know.

GENERAL COUNSEL: You were part of the investigation weren't you?

MS. AMES: I - -[CMC Counsel's request for additional clarification].

Tr. p. 763. Even after General Counsel again clarified the question, Ms. Ames continued displaying a stunning degree of either short-term memory loss or flagrant hostility toward the proceedings:

GENERAL COUNSEL: Did the peer review committee meet on two separate occasions, with respect to the September 11th 2016 incident?

MS. AMES: I don't know.

²¹Notably, Interim Director Crumb was responsible for the "rigged" investigation of Ms. Marshall in 2015. *Goldman Dec.*, p. 52. Arguably in an effort to sanitize this investigation, Ms. Ames was made the "lead investigator." *Tr. pp. 835-40*.

*Tr. p. 764.*²² When questioned by the General Counsel, Ms. Ames admitted being aware of Ms. Marshall's union activity.²³ *Tr. p. 3381.*

Ms. Ames' investigation consisted of two conversations with the Patient, a single conversation with her sister, Star York, informal discussions with four ICU nurses²⁴ and a single conversation each with Ms. Lamb and Ms. Marshall, the latter clearly after a decision to terminate had been made.²⁵

According to Ms. Ames, she first interviewed the Patient on September 14, after she left the ICU.²⁶ *Tr. p. 3222.* Although Ms. Ames took notes during the discussion, she destroyed them

²²Weeks later, perhaps in an attempt to resuscitate her credibility, CMC called Ms. Ames back to testify. *Tr. pp 3161-2.*

²³Indeed on August 22, 2016, less than a month before the at-issue incident, an email from Ms. Marshall was forwarded to Ms. Ames. *Exh. GC-72.* In the underlying email, Ms. Marshall exhorts her co-workers to support 1199, referencing the amount the Hospital has spent fighting unionization, hiring travel RNs, etc. *Id.*

²⁴By all accounts, Ms. Ames went to the ICU on one or more occasions and spoke with four nurses who happened to be available about their practices relative to transfusions. *Tr. p. 3397.* This did not appear to be particularly methodical nor did she speak with more than a handful of staff. Of the three nurses who spoke with Ms. Ames who testified, all averred that they told her they do not always do a two RN bedside check. *See Tr. pp. 913-5, 1081-2, 1705.* Query: Did Ms. Ames decide against speaking with more ICU nurses because what she learned undermined any credible basis to terminate Ms. Marshall and Ms. Lamb?

²⁵Admittedly Ms. Marshall was on vacation and out of state from September 13 through October 3. *Tr. pp. 3497-8.* Thus she was unavailable to be interviewed until October 4. *Tr. pp. 3497-8.* CMC bears no responsibility for the delay in interviewing Ms. Marshall; rather, its culpability lies in making a decision to terminate before speaking with her. This is of critical importance since, by her own admission, Ms. Lamb never entered the Patient's room. *Tr p. 1552.* Thus only by waiting to speak with Ms. Marshall could the Hospital gain her position on what efforts to identify the Patient she made in the room.

²⁶As noted *supra*, because the Hospital waited to call the Patient until the end of its defense, she was unable to testify due to failing health. *See Tr pp. 475-7, 3224-31.* Thus any

shortly after she “put them into the incident reporting [system]” *Tr. p. 3384; see also, Exh. E-4.*

Ms. Ames interviewed the Patient a second time by phone on September 16. *Tr. p. 3392.* In this call, the Patient expressed that staff were not using neutropenic precautions and that on the day of her discharge, her prescriptions were delayed in queue, preventing her from picking them up immediately. *Tr. p. 3476; see also Exh. GC 68.* Ms. Ames took notes during the conversation, but again destroyed them shortly afterward; however, this time she did not place them into the incident reporting system. *Tr. pp. 3392-3.*

Ms. Ames could not provide a clear explanation as to what the Patient related about Ms. Marshall’s alleged comments. For instance, when asked pointedly by General Counsel “who asked what in the room on September 11, 2016,” Ms. Ames replied cryptically,

I know that it was brought up to the patient—or the patient brought up to—and the sister to Anne what about the protocol? And Anne said we don’t have to do that here. I don’t know which date it was that she said that, when I talked to the patient and the sister, but I know the patient and the sister were told we don’t have to do that here, in response to why they didn’t see two nurses coming in, like they had all other previous times.

Tr. pp. 3387-8.

In short, Ms. Ames’ memory of who said what and when was garbled, at best. Her memory was remarkably deficient in several areas, as well. For instance, she testified that in her six to seven years as Chief Patient Safety Officer and Director of Quality and Patient Safety she has handled thousands of incident reports, yet she could not recall a single event other than the September 11 transfusion. *Tr. pp. 834-43.*

Patient statements are necessarily hearsay.

In addition to the foregoing "investigation," Ms. Raupers spoke to the Patient on September 20.²⁷ *Tr. p. 3472*. She urged the Patient to submit a written complaint, which she did. *Tr. p. 3474-5*. Although, as discussed *supra*, the Patient and her sister complained about the lack of neutropenic precautions, lack of green caps, failure to wear gloves and delayed relaying of the discharge script, nothing indicates Ms. Raupers requested the patient submit a complaint about any of these grievances. *See Tr. p. 3475*.

VIII. NURSING PEER REVIEW COMMITTEE MEETINGS

The Hospital maintains a Nursing Peer Review Committee which is supposed to be comprised of at least one nurse from each CMC department that performs direct patient care. *Tr. p. 761; see also Exh. GC 15*. Based on the written Policy, a member is assigned to review and present each case referred to the Committee. *See Exh. GC 15*. Following this presentation, the members discuss the case and what further actions should be considered. *Id.* At the conclusion, a summary and recommendations are drafted and forwarded to the appropriate department. *Id.*

The Peer Review Committee discussing the at-issue transfusion convened on September 19, notably before anyone involved had spoken with Ms. Marshall or Ms. Lamb. *Tr. p. 3478*. It does not appear that a member of the Committee had been assigned to review and present the case. Rather, the Committee reviewed the Patient's chart and looked at the blood administration record. *Tr. p. 3478*. According to Ms. Raupers,

They looked at the patient chart. They looked at the blood administration record. They looked at the order. They followed through the entire blood process because that's what they were told to look at. And at the end of that they gave a summary

²⁷She did not speak with the Patient's sister until after Ms. Marshall and Ms. Lamb were terminated, making the conversation wholly irrelevant to the matter at-bar. *Tr. pp. 3589-90*.

finding...[t]hat basically by documentation it looked like everything was correct, everything was done appropriately.²⁸

Tr. pp. 3478-9; see also Exh. GC 69. Linda Crumb reported these findings to Ms. Raupers. *Tr. p. 3479.* Apparently dissatisfied that Peer Review found no wrongdoing, Ms. Raupers ordered the Committee to re-convene. *Tr. p. 3480.*

The Peer Review Committee re-convened on September 23. *Tr. p. 3481.* Determined to insure a particular outcome, both Ms. Ms. Raupers and Ms. Ames attended this meeting. *Id.* The meeting commenced with Ms. Ames reading the patient complaint to the members.²⁹ *Tr. p. 3482.* Thereafter, Ms. Raupers excused Ms. Ames and permitted Terri McShane, Director of the Maternity Department, to “talk[] through” the matter with the nurses. *Tr. p. 3482.* Ms. Raupers, as Chief Nursing Officer for CMC, remained present throughout, including while the nurses completed the written committee summary. *Tr. p. 3437, 3482, 3484; see Exh. GC 16.* Although the Committee is supposed to be comprised of a representative from each department, there was no one from the ICU on the Committee.³⁰ *Tr. p. 2858, see also GC Exh. 16.* The lack of anyone

²⁸By looking at the Patient chart and the blood card, the Committee members would know the identity of “anyone that’s cared for the patient.” *Tr. pp. 3142, 3145.*

²⁹There is no indication the Committee knew that Ms. Lamb verified the blood and the patient’s identity, either at the desk or the bedside. Most alarmingly, the Committee never heard Ms. Marshall’s side of the events, including that she checked the Patient’s identity and wrist band before administering the transfusion. *See Tr. pp. 1228-29.*

³⁰Also deviating from the Policy, there were three members from a single department, Maternity. *See GC Exh. 16.*

from ICU is very significant, given that the practice in the ICU deviates from the formal Blood Policy.³¹

IX. THE TERMINATIONS OF MS. LAMB AND MS. MARSHALL

On September 20, 2016, CEO John Rudd's secretary called Ms. Lamb at her home, requesting that she report to Ms. Ames' office before the start of her shift.³² *Tr. p. 1549*. At the time, Ms. Lamb assumed it was to discuss an incident wherein an ICU patient died because her Levophed drip was not refilled, which was largely due to under-staffing in the ICU. *Tr. pp. 1533-4, 1550*. To her shock, when Ms. Lamb arrived the next day, she was met by Karen Ames and Linda Crumb, who interrogated her over the September 11 transfusion.³³ *Tr. p. 3489; see also Exh. E 11*. At the conclusion of the meeting, Ms. Crumb informed Ms. Lamb that she was suspended. *Tr. p. 3493*. CMC management awaited Ms. Marshall's return from vacation before taking any further action. *Tr. p. 3302*.

For most, if not all, of the Hospital's investigation, Ms. Marshall was unavailable to relate her side of the events as she was on vacation in the West Coast and did not return until

³¹CMC witness Terri MacShayne sought to excuse the failure of the ICU to have a representative, explaining "We don't pull people in to do peer review because people don't really understand it just to come to one meeting. Peer review is more about systems and process. *It's not about finding fault*. And people who just jump in don't really understand that fact." *Tr. p. 2857*. This misses the point: The problem is not so much that the Committee did not follow its own protocol, but that having a nurse from the ICU on the Peer Review Committee would have revealed the different practices there.

³²ALJ Goldman noted previously the "the involvement of so much senior management is unusual." *Goldman Dec., p. 48*. Query: Why did Ms. Lamb receive a phone call from the Hospital CEO's secretary instead of Ms. Ames, who was in charge of the investigation?

³³Ms. Lamb had worked subsequent to September 11 and was wholly unaware there was "an incident" or problem. *Tr. p. 1549*.

October 4, after the investigation was essentially completed. *Tr. pp. 3497-8*. After returning from vacation, Ms. Marshall was immediately summoned to meet with Ms. Ames and Ms. Raupers, although not to obtain her side of the story as much as to convey that she was suspended. *Tr. pp. 3359-62*. When asked how much of the investigation was completed prior to the suspension, Ms. Ames was uncharacteristically candid, "By the time she was suspended, we were wrapping up the investigation." *Tr. 3360*.

On October 5, again CMC called in Ms. Lamb, this time to complete her termination with Ms. Raupers and Interim Director Crumb. *Tr. p. 1560*. Like Ms. Marshall, Ms. Lamb had never been disciplined before the September 11 transfusion. *Tr. p. 1565*. In fact, her annual performance evaluations from 2011 to 2016 indicated she "Frequently Performs Beyond Expectations." *Exh. GC 42*. Ms. Lamb was clearly distraught and in disbelief when informed she could no longer work at CMC. *Tr. p. 1562*. Ms. Raupers concluded the meeting with a striking statement: "...I can't treat you and Anne differently to be honest."³⁴ *See Tr. pp. 3548-50; Exh. E 26(b), p. 11*.

The next day, October 6, CMC ended Ms. Marshall's employment. *Tr. 1249*. Within hours, an unprecedented email was distributed widely to CMC staff, volunteers and physicians with admitting privileges regarding the September 11 transfusion and related terminations.³⁵ *Exh. GC 7*. Given that the Patient had no adverse reaction to the transfusion and thus there is no basis

³⁴Ms. Raupers' efforts to explain this statement clearly rang hollow. *See Tr. pp. 3549-54*.

³⁵The two witnesses with the longest tenure at CMC, Ms. Tregaskis and Ms. Crumb, had never seen a similar email *Tr. p. 915, 3132*. To the extent Ms. Crumb claimed any memory of such a prior communication, it predated the existence of email and her testimony (and recollection) were vague, at best. *See Tr. p. 3132*

to suspect her complaint was known widely, it is unclear what prompted the Hospital to issue such a communication, except to besmirch Ms. Marshall and Ms. Lamb.

X. DISPARATE TREATMENT OF MS. MARSHALL AND MS. LAMB

As referenced above, this is not the first time CMC has attempted unlawfully to discipline Ms. Marshall. *See generally, Goldman Dec.* It should be noted that ALJ Goldman found “no evidence at all that the Respondent has ever suspended or taken action against an employee for anything remotely similar to the charges levied against Ms. Marshall.” *Goldman Dec., p. 49.* In fact, he determined that CMC’s “comparator evidence” served only to undermine CMC’s prior defenses, finding that

Marshall’s suspension for a first ever offense stands in stark contrast to the historical record provided by the Respondent for the purposes of buttressing its case. There was no counseling for Marshall. No “written warning,” no improvement plan preceding suspension. Rather, the Respondent, in an apparent unprecedented action, went straight to suspension for Marshall.

Goldman Dec., p. 49.

A. The Comparator Evidence Reveals That CMC Implements Progressive Discipline, Even When Nurses Commit Egregious Errors

In the instant matter, CMC’s comparator evidence relative to employees terminated for purportedly like conduct demonstrates the disparate treatment of Ms. Marshall and Ms. Lamb. *See Tr. pp. 2144-99, 2221-70.* A review of the facts of the various comparator terminations is instructive.

In 2009 the Hospital terminated cardiac rehab unit RN Deborah Noonan for falsifying records *Tr. pp. 2145-7.* The cardiac rehab unit maintains a “crash cart,” stocked with life-saving

equipment, such as medications, syringes and at least one defibrillator. *Tr. p. 2147.* Ms. Noonan was tasked with checking the cart monthly and filling out a checklist indicating the items were not expired and were on the cart. *Id.*

While performing a routine check, a Director discovered that Ms. Noonan had filled out four or five crash cart checklists several months in advance. *Tr. pp. 2143, 2152.* The checklists were completed “with the exception of the date being filled in.” *Tr. p. 2149.* Moreover, it was discovered the crash cart had expired items and missing items. *Tr. p. 2150.* Given that Ms. Noonan was counseled six or seven times previously, including for keeping incomplete patient records, failing to obtain informed consent certifications and not completing discharge forms, she was terminated for falsifying records and failing to perform assigned duties. *Tr. pp. 2151, 2155-60; see Exhs. E-31(a)-(b) and GC 47-8.*

The Hospital terminated telemetry unit aid Joanne McDonald for purportedly falsifying documents in December, 2015. *Tr. p. 2221.* Prior to her termination, Ms. McDonald received a series of progressive disciplines, including, “multiple counseling, verbal, written warnings and suspension.” *Tr. pp. 2245-8; Exhs. GC 32a, 49.* For months, Ms. McDonald was on a work improvement plan. *Tr. p. 2246.* According to CMC Director Kansas Underwood, Ms. McDonald “struggled with her professionalism in her nursing code—or her code of conduct.”³⁶ *Tr. p. 2224.* As Ms. Underwood testified, in light of her previous performance-related issues, “when she falsified records, that was for me the decision that she was not the right fit for Cayuga Medical Center.” *Tr. pp. 2224-5.*

³⁶ALJ Goldman found several provisions of this Nursing Code of Conduct to be unlawful.

Ms. Smith-Parris was a short term aid in the telemetry unit. *Tr. p. 2225*. She was terminated following concerns regarding the veracity of vital signs entered into patient charts. *Id.* She also had “arrival” and “attendance” issues and struggled “with the daily tasks of patient care, environmental upkeep, and accurate documentation within her role as health aide.” *Exh. GC 50a*.

Finally, Catherine Ritchie was involved in a “near-miss” blood transfusion in 2012.³⁷ Although she was terminated, the incident was not her first transgression and it was entirely unclear the near-miss was the reason for her departure.³⁸ *Tr. p. 3196*. On September 4, 2012, Ms. Ritchie administered an overdose of Dilaudid to a patient. *Tr. p. 2439*. Previously she was confronted about signing excessive narcotics and non-preferred doses without a witness. *Tr. p. 2429*. Moreover, she had failed to document certain narcotics in a patient’s medical record. *Id.* In short, there were ample grounds to terminate Ms. Ritchie.

B. CMC Presented No Evidence Indicating Discipline Issued For Events Resulting In Incident Reports

CMC operates an incident reporting system whereby suspected errors and violations of Hospital policies can be reported. *See Tr. pp. 314, 757; see also Exhs. GC 8 - 14*. After an

³⁷In testifying as to the 2012 near-miss, Nathan Newman, a current CMC nurse, was provided no assurances that he would not face reprisal for refusing to participate in the Hospital’s examination and questioning at trial. *See Tr. pp. 2512-3*. In fact, Mr. Newman testified that he was not told specifically that his participation in the proceedings was voluntary. *Tr. p. 2514*. This resulted in amended of Complaint at the hearing. *See, Argument, Point III, infra*.

³⁸CMC could not confirm in a straightforward manner whether Ms. Ritchie’s entire employment file was produced, as requested in General Counsel’s subpoena. *See Tr. pp. 2440-4*.

incident is submitted,³⁹ the relevant director receives an email notification that a report has been generated. *Tr. p. 2295*. The report contains a brief factual description, contributing factors and reference to requested follow-up action, if any. *Tr. p. 819*. The incident reports, or QAs, range in severity level, with the more hazardous incidents labeled “serious safety event classification.” *See Exhs. GC 8-14*.

From about May, 2015 to September 8, 2016, CMC received at least nine QAs relative to medication and IV safety incidents ranked at a level two, indicating “Temporary Minor Harm/Damage.”⁴⁰ *See Exhs. GC 9(a)-(i)*. Generally these QAs involved giving the wrong medication and untimely and/or missed dosages. *Id.* From December 27, 2012 to December 30, 2016, CMC received approximately 21 transfusion-related QAs, ranging in severity from 0 to 1. *See Exhs. GC 10(a) - (e); GC 11(a) - (p)*. CMC offered no evidence any of the nurses involved in these transfusion-related incidents were investigated, much less disciplined similarly to the September 11 transfusion.

In addition to the above, CMC received at least 10 transfusion-related QAs involving suspected adverse reactions (*Exhs. GC 12(a) - (j)*) and five transfusion-related QAs involving deviations from standard operating procedure. *See Exhs. GC 13(a) - (e)*. The severity levels ranged from 0 to 2. *Id.* From at least June 17, 2015, to December 30, 2016, CMC received 13

³⁹Incidents are referred to, also, as a “QA.” *Tr. p. 314*.

⁴⁰Despite the level two severity rankings, CMC presented no evidence that these incidents resulted in discipline, much less termination. This is notable considering the QA relative to the September 11 transfusion was ranked at level zero. *See Exh. E 4; cf. Exhs. GC 9(a)-(i)*.

QAs involving what the Hospital calls “red rule” violations. *Exhs. GC 14(a)-(m)*. When asked at trial whether she could recount the details or the results of any investigations relating to these QAs, Ms. Ames admitted she could not. *See Tr. pp. 818-33*.

Shortly prior to the September 11 transfusion, an “ID/Documentation/Consent” QA was submitted on July 13, 2016, wherein a nurse failed to scan a patient’s wrist band bar code. *See Exh. GC 29*. In this incident, the nurse admitted to making a mistake. *See Exhs. GC 30-1*. Moreover, CMC management recognized this was not a “one-off” and that “nurses regularly mak[e] this error,” and were “clearly teaching each other short-cuts.” *Id.* Despite the apparent prevalence of the action, CMC presented nothing indicating the nurse was terminated.

The severity level with respect to the Marshall/Lamb QA was “0;” there was no patient harm; and the follow up action was “policy/procedure reviewed” and “staff reinstructed.” *Exh. GC 4*. Yet CMC used this single incident as grounds to terminate the employment of two nurses with otherwise stellar records.⁴¹

XI. CMC’S PRETEXTUAL PLANNING

Relative to his duties, John Turner oversees communications with the public and CMC employees. *Tr. p. 887*. On September 27 and as a part of the CMC “investigation,” John Turner contacted Ms. York by phone.⁴² *Tr. pp. 878-9*. In their discussion, Ms. York identified four

⁴¹It should go without saying that the prior discipline of Ms. Marshall had to be discounted, given the Goldman Decision. *Goldman Dec., passim*.

⁴²Mr. Turner is the Hospital’s Public Relations Specialist. *Tr. p. 875*. By his own admission, he has no medical background. *Tr. p. 883*. It is telling that CMC would task him with speaking with Ms. York. This makes sense only if the purpose of the call was to find grounds to rid the Hospital of a major public relations problem in the form of the Union campaign.

problems: the failure to take neutropenic precautions; the lack of green antibacterial caps on central lines; the absence of staff members using gloves when providing treatment; and the September 11 transfusion involving Ms. Marshall and Ms. Lamb. *Exh. GC-18; Tr. pp. 880-1*. Mr. Turner documented this conversation contemporaneously. *See Exh. GC 18*. Revealingly, in his testimony Mr. Turner attributed all four complaints to Ms. Marshall and Ms. Lamb.⁴³ *See Tr. pp. 882-3*. Yet in her testimony, Ms. York made clear that she did not have a concern about neutropenic precautions, failure to wear gloves nor the green caps on the central lines, as pertained to Ms. Marshall and Ms. Lamb. *Tr. pp. 460-3, 504-5*. Specifically, she recounted:

STAR YORK: ...[T]here were times when I felt the precautions weren't being followed.

GENERAL COUNSEL: But, when you said that, you weren't specifically referencing Anne, right?

STAR YORK: No.

GENERAL COUNSEL: And, you weren't specifically referencing Anne with the green caps and the central line either, right?

STAR YORK: No.

GENERAL COUNSEL: Or the other neutropenic precautions with respect to the mask, correct?

STAR YORK: No.

GENERAL COUNSEL: So, in addition to the issue that you took with what happened in the blood transfusion, there were other issues that you were having with respect to your sister's care at Cayuga Medical Center; would you agree with that?

STAR YORK: Yes.

GENERAL COUNSEL: And, you brought those to John [Turner]'s attention; is that right?

STAR YORK: I did.

Tr. p. 504.

⁴³Simply stated, Mr. Turner was not credible.

On September 29, prior to the interview of Ms. Marshall and ostensibly before a final decision was made, Mr. Turner provided Hospital CEO John Rudd with a draft letter for distribution to CMC staff. *Tr. pp. 884-5; see Exh. GC 19*. The letter contained an excerpt of the complaint the Patient drafted at the request of Ms. Raupers. *See Exh. GC 19*. Significantly, the communication to staff mentioned the Patient's concerns about Ms. Marshall and Ms. Lamb, not her others ones. *See Exh. GC 19*. Revealingly, Mr. Turner expressed in the body of the email, "[i]f Anne Marshall launches and things go public before the BOD meeting, I think we should send them the attached internal communication with a slight revision." *Exh. GC 19*.

Several days later, on October 3, immediately prior to the terminations but still *before* CMC spoke with Ms. Marshall, Mr. Turner sent an email to Vice President of Human Resources Forrest, containing several hypothetical questions and answers, all premised on Ms. Marshall and Ms. Lamb being terminated. *Tr. p. 895; Exh. GC 21*. Perhaps not surprisingly, the first anticipated question was "We are told that you terminated the employees to bust the efforts of the Union, is that right?" *Id.*

Revealingly, although CMC had not spoken with Ms. Marshall at the time Mr. Turner drafted this communication⁴⁴ and theoretically CMC had not decided to terminate, nonetheless, Mr. Turner added the line, "as a result we have parted company with the two nurses involved in this case." *Tr. p. 893*. According to Mr. Turner, he added termination as opposed to some other outcome because,

⁴⁴Given that only Ms. Marshall, the Patient and her family knew what happened in the room, the importance of the Marshall interview cannot be overstated.

I know the investigation was completed. I knew all the facts had been gathered. I knew the general direction. I think with Ms. Marshall there was a delay, because of a scheduling issue on her end, getting her in there. But it was pretty clear the direction this investigation was taking and it was completed.

Tr. p. 894. The termination message was ultimately dispatched on the Hospital's listserv. *Tr. p. 891.*

ARGUMENT

Point I

The Employer Violated the Act When it Terminated Anne Marshall and Loran Lamb

Sections 8(a)(1) and 8(a)(3) of the National Labor Relations Act, 29 U.S.C. §§158(a)(1) and (3), prohibit an employer from discriminating against employees who engage in protected, concerted activity. *NLRB v. Wright Line*, 662 F.2d 899, 901 (1st Cir. 1981), cert. denied 455 U.S. 989 (1982). Protected, concerted activity refers to employees acting together to improve working conditions, including in the context of a union organizing campaign. *NLRB v. Great Dane Trailers, Inc.*, 388 U.S. 26, 32 (1967); *see also, e.g., 800 River Rd. Operating Co. LLC v. NLRB*, 784 F.3d 902, 914, 918 (3rd Cir. 2015); *NLRB v. Aluminum Casting & Eng'g Co.*, 230 F.3d 286 (2000). The determination of whether there has been a violation of §§8(a)(1) and (3) is made by applying the "*Wright Line* analysis," as outlined in *Wright Line Div.*, 251 NLRB 1083 (1980), *enfd.* 662 F.2d 899 (1st Cir. 1981), cert. denied 455 U.S. 989 (1982).

Initially, General Counsel must demonstrate by a preponderance of the evidence that "union animus was a substantial or motivating factor...." *Consolidated Bus Transit, Inc.*, 350 NLRB 1064, 1065 (2007). The elements required for this initial showing are (1) the employee

was engaged in protected, concerted activity; (2) the employer was aware of the activity; and (3) the employer's actions were influenced by union animus. *Id.* Unlawful motivation and union animus are often established by indirect or circumstantial evidence, such as disparate treatment of workers for similar offenses. *Robert Orr/Sysco Food Services, LLC*, 343 NLRB 1183, 1184 (2004), *enfd.* 184 Fed. Appx. 476 (6th Cir. 2006); *Embassy Vacation Resorts*, 340 NLRB 846, 848 (2003). However, if an employer's conduct is "inherently destructive" of employee rights, then

no proof of antiunion motivation is needed and the Board can find an unfair labor practice even if the employer introduces evidence that the conduct was motivated by business considerations.

Great Dane Trailers, Inc., 388 U.S. at 34.

Once the General Counsel has made an initial showing, the burden shifts to the employer to establish, by a preponderance of the evidence, that the same action would have been taken, for a legitimate reason, absent the protected activity. *Consolidated Bus Transit, Inc.*, 350 NLRB at 1066.⁴⁵ The General Counsel must then show either that the employer's motives were both lawful and unlawful (a "mixed motive" case, *see e.g. Golden State Foods Corp.*, 340 NLRB 382, 385 (2003)) or that the employer's proffered reasons are pretextual (*see, e.g., Limestone Apparel Corp.*, 255 NLRB 722 (1981), *enfd.* 705 F.2d 799 (6th Cir. 1982)). *See generally, Wright Line*, 251 NLRB at 1083.

⁴⁵It is not sufficient for the employer merely to show a legitimate reason for disciplining the employee; the employer must show by a preponderance of the evidence that the discipline would have taken place even if the employee had not engaged in protected conduct. *North Carolina License Plate Agency #18*, 346 NLRB 293, 294 (2006).

A. CMC Knew Ms. Marshall and Ms. Lamb Were Engaged In Protected Activity

Employees engage in protected, concerted activity when they act together to improve working conditions, with or without a union. *NLRB v. Caval Tool Div., Chromalloy Gas Turbine Corp.*, 262 F.3d 184, 189 (2d Cir. 2001). Such conduct occurs frequently in the context of a union organizing campaign. *See, e.g., Golden State Foods Corp.*, 340 NLRB 382; *Robert Orr/Sysco Food Svcs., LLC*, 343 NLRB 1183; *Stoody Company, Div. Of Thermadyne, Inc.*, 312 NLRB 1175 (1993); *Alle-Kiski Medical Center*, 339 NLRB 361 (2003); *United Refrigerated Svcs., Inc.*, 325 NLRB 258 (1998); *Somerset Valley Rehabilitation and Nursing Center*, 358 NLRB 1361 (2012), *aff'd* 825 F.3d 128 (3d Cir. 2016).

Somerset Valley is particularly instructive. Therein nursing employees were active during an organizing campaign by, *inter alia*, speaking to their co-workers in support of the union, circulating pro-union petitions, distributing authorization cards, appearing in a pro-union video, holding union meetings, wearing pro-union stickers, and appearing on a pro-union brochure. *Id.* at 1366. Several were disciplined and discharged for absenteeism and medical documentation issues. *Id.* at 1388-91. The employer's conduct in disciplining the union supporters before, during, and after the representation election (which the Union won) was held to violate §§8(a)(1) and (3). 358 NLRB at 1361-63.

i. The Hospital Viewed Anne Marshall As The Union Campaign "Ringleader"

Here, it is not disputed that CMC nurses were engaged in a union campaign. Without question, CMC was well aware that Ms. Marshall advocated vigorously and openly for union

representation, and to improve working conditions. *Goldman Dec.*, p. 46. In fact, referring to her activities in support of 1199, ALJ Goldman wrote:

The Respondent's knowledge of this is not in doubt. She was identified as “a ringleader” by management as of May [2015], and her activities were reported to management, and indeed, a report on her activities was solicited on June 2, and the response included reference to her union activities.

Goldman Dec., p. 46. ALJ Goldman held additionally, “there is significant evidence of animus directed like a laser on Marshall and her union and protected activities.” *Goldman Dec.*, p. 47.

Ms. Marshall’s union activities persisted beyond the first ULP hearing: She hosted union meetings, posted information on the CMC bulletin board about 1199, distributed union literature in non-patient areas and tabled in the Hospital cafeteria. *Tr. pp. 1185-6*. Indeed, there can be little dispute that Ms. Marshall was, for all intents and purposes, the face of the Union at CMC.

Relative to the current ULP, there is ample evidence that CMC determined its actions with regard to Ms. Marshall in the context of the Union campaign. For instance, despite receiving multiple complaints from the Patient and her sister, unrelated to the specific transfusion, CMC attributed all culpability to Ms. Marshall’s nursing care, contrary to the complaint that “not all the caregivers who came in followed [neutropenic precautions].” *Tr. 881-3; cf. Tr. pp. 460-3*. As Public Relations Specialist John Turner testified unequivocally, CMC paid no attention to any of the failures of the other caregivers, instead building a case for removing Ms. Marshall and Ms. Lamb and thus seeking to rid itself of 1199. *See Tr. pp. 879-83*.

Mr. Turner prepared CMC’s statements relative to the terminations knowing and anticipating the unfair labor practice implications. *Tr. pp. 883-8; Exh. GC 19*. The timing of Mr. Turner’s letter is critical, considering it was submitted to the CEO *before* Ms. Marshall and Ms.

Lamb were actually terminated.⁴⁶ *Id.* Likewise, Human Resources Vice President Brian Forrest, who lead the charge with CMC's "Next Steps for Response to Union," demonstrated the Hospital's primary concern was public relations, not patient safety, spearheading the "damage control" relative to ALJ Goldman's ruling. *Tr. pp. 1019-20; Exhs. GC 23, 24.* Unquestionably, CMC's actions relative to the September transfusion were aimed at removing Ms. Marshall, without regard to the claimed concerns for patient safety.

ii. CMC Terminated Ms. Lamb Largely To Hide Discriminatory Conduct Against Ms. Marshall

In the context of an organizing campaign, where an employer discharges a supposedly neutral employee in order to hide discriminatory conduct against a known union supporter, the discharge is a violation of §8(a)(3). *Embassy Vacation Resorts*, 340 NLRB at 848 n. 13; *see also Dawson Carbide Industries*, 273 NLRB 382, 389 (1984), *enfd.* 782 F.2d 64 (6th Cir. 1986) (such employees are "pawns in an unlawful design"). For example, in *St. John's Community Svcs. - New Jersey*, a nurse who had not engaged in protected, concerted activity was nevertheless discharged when an employer responded to other employees's union activities by tightening enforcement of its medication administration policy. 355 NLRB 414, 419 (2010). The employer stated during the termination interview, "with all this stuff with the union...we have to go by the book." *Id.* at 421. Prior to the union campaign, employees were not discharged for their first medication error. *Id.* at 422-23. This "crackdown" in response to the union's activities was

⁴⁶It should be noted that Mr. Turner's email was sent to the Hospital's CEO and that in ALJ Goldman's decision, he found that in regards to the decision to discipline Ms. Marshall, "the involvement of so much senior management is unusual." *Goldman Dec.*, p. 48.

found to violate §§8(a)(1) and (3). *Id.* at 426.⁴⁷ See also, *Heartland of Lansing Nursing Home*, 307 NLRB 152, 152-53 (1992).

Although Ms. Lamb was openly supportive of the Union campaign, she was, admittedly, more soft-spoken than Ms. Marshall. See *Tr. pp. 1186-7, 1525-7*. Assuming *arguendo* CMC was unaware of Ms. Lamb's protected activity, its discharge of her at the same time as it discharged Ms. Marshall is strongly suggestive of an unlawful motive. Indeed, at the October 5 termination meeting, Ms. Raupers stated candidly, "...I can't treat you and Anne differently to be honest." See *Tr. pp. 3548-50; Exh. E 26(b), p. 11*.

Like *St. John's*, where the employer, in the context of a union campaign, terminated a supposedly neutral employee for a first time medication error, in the matter at-bar, CMC terminated Ms. Lamb for conduct consistent with common practices in the ICU, despite having no prior discipline and years of evaluations noting she "Frequently Performs Beyond Expectations." *Tr. p. 1565; Exh. GC 42*. Clearly, Ms. Marshall had a target on her back. CMC was willing to cast as wide a dragnet as necessary to stop the Union activities, even if it meant sacrificing Ms. Lamb, an exceptionally dedicated nurse.

B. CMC Was Motivated By Anti-Union Animus

Unlawful motivation may be inferred from, *inter alia*, disparate or inconsistent treatment. See e.g., *Columbia Mem. Hosp.*, 362 NLRB No. 154, 9 (July 30, 2015); *Carpenters' Health &*

⁴⁷Similarly, where pro-union, neutral or anti-union employees are all dismissed as part of a layoff made to discourage union activity, there does not need to be a showing of the employer's awareness of the union sympathies of each laid-off employee. *Stark Electric, Inc.*, 324 NLRB 1207, 1210 (1997); citing *Davis Supermarkets*, 306 NLRB 426 (1992), *enfd.* 2 F.3d 1162, 1168 (D.C. Cir. 1993); *Alliance Rubber Co.*, 286 NLRB 645, 647 (1987), *NLRB v. Frigid Storage, Inc.*, 934 F.2d 506, 510 (4th Cir. 1991); *Active Industries*, 277 NLRB 376, 376 n.3 (1985).

Welfare Fund, 327 NLRB 262, 265 (1988); *Royalite*, 324 NLRB 429, 430 (1997). Of particular relevance to the matter at-bar is *Affinity Medical Center*. 362 NLRB No. 78 (April 30, 2015).

In *Affinity*, in the context of an organizing campaign, a nurse who was a vocal union supporter was discharged and reported to a state regulatory board for several alleged offenses, including falsifying a patient chart. 362 NLRB No. 78 at 14. It was determined that, even if the nurse was guilty of all of the alleged offenses, the employer's decision to terminate her was much harsher than any disciplinary action for similar offenses it had taken in the past. *Id.* The alleged violations had no bearing on the patient's health and other nurses had been treated leniently for far more serious conduct. *Id.* The disparate treatment was found to be evidence of discriminatory intent; hence, the employer was ordered to reinstate the nurse and rescind its complaint to the state. *Id.* at 2, 16-17.

Similarly compelling is *Norton Audubon Hospital*, 341 NLRB 143 (2004). Therein, in the context of an organizing campaign, a pro-union nurse who administered a placebo to a patient was discharged. 351 NLRB at 150. The employer claimed that the placebo was against policy, discharged the nurse, and reported her to the state regulatory agency. *Id.* However, other nurses making comparable mistakes were not treated so harshly. *Id.* at 152-56. Consequently the disparate treatment was evidence of the employer's anti-union motive, and the nurse was reinstated.⁴⁸ *Id.* at 143, 152-56. *See also, Nursing Center at Vineland*, 314 NLRB 947, 955-56 (1994) (LPNs falsely accused and reported to state regulatory ombudsman because of protected activity in organizing campaign).

⁴⁸The state agency had already found the report unfounded. 314 NLRB at 955-56.

Here, Ms. Lamb and Ms. Marshall worked for CMC in the ICU until terminated on October 5 and 6, respectively. *Tr. pp. 1183-5, 1525*. Prior to the organizing campaign, Ms. Marshall had “an unbroken record of superlative annual personnel reviews” dating back to her initial hire. *Goldman Dec., p. 38*. Indeed, Ms. Marshall's leadership skills were recognized in 2013, when the Hospital promoted her to Team Leader. *Goldman Dec., p. 38*. She had an “unblemished disciplinary record” until CMC suspended her unlawfully for engaging in protected, concerted activity in 2015. *Goldman Dec., p. 38*.⁴⁹ Although she had less longevity at CMC and never reached the status of Team Lead, Ms. Lamb also had a prior, unblemished record. *Tr. p. 1565*.

Moreover, CMC's comparator evidence demonstrates markedly disparate treatment for similar and far more egregious conduct. For instance, CMC terminated nurse Deborah Noonan for filling out crash cart checklists several months in advance, claiming she “falsified documents.” *Tr. pp. 2143, 2152*. Clearly Ms. Noonan did falsify documents, but she was terminated only after receiving six or seven prior counselings for other offenses, including documenting patient procedures inappropriately. *Tr. pp. 2151, 2155-60; see Exhs. E-31(a)-(b) and GC 47-8*. Reasonable people can differ on whether Ms. Marshall and Ms. Lamb falsified documents.⁵⁰ Regardless, they were terminated after a first, alleged offense, with no prior warning.

⁴⁹Ms. Marshall was eventually cleared of the alleged wrongdoing by ALJ Goldman.

⁵⁰The allegation of document falsification rests on the reality that Ms. Marshall and Ms. Lamb completed the transfusion card at the desk, not in the patient room. Yet this was common within the ICU. *See Tr. pp. 1545-6, 1709*. Moreover, with respect to Ms. Marshall, at least, it raises form over substance, since she checked everything in the room as well. *Tr. pp. 1228-9*.

CMC terminated Joanne McDonald for purportedly falsifying documents in December, 2015, but only after a series of progressive disciplines, including, “multiple counseling, verbal, written warnings and suspension.” *Tr. pp. 2221, 2245-8; Exhs. GC 32a, 49.* Indeed, Ms. McDonald was on a work improvement plan for months before CMC removed her. *Tr. p. 2246.* In addition to “professionalism” issues, management finally determined that “she was not the right fit for Cayuga Medical Center.” *Tr. pp. 2224-5.*

Raven Smith-Parris was terminated following concerns regarding the veracity of vital signs entered into patient charts. *Tr. p. 2225.* She also had “arrival” and “attendance” issues and struggled “with the daily tasks of patient care, environmental upkeep, and accurate documentation within her role as health aide.” *Exh. GC 50a.* Even though Ms. Smith-Parris worked at CMC for a very brief period, she was still afforded extensive, progressive and remedial discipline. *Tr. p. 2227.*

General Counsel produced scores of QAs, documenting medication errors and charting mistakes. *See Exhs. GC 8-14.* CMC did not provide a shred of evidence that any of the staff who were the subject of any of these QAs were disciplined. *See Exhs. GC 8-14; cf.* This stands in sharp contrast to the QA at issue herein. *Exh. E-4.* The severity level with respect to the Marshall/Lamb QA was “0;” there was no patient harm; and the follow up action was “policy/procedure reviewed” and “staff reinstructed.” *Id.*

Notwithstanding the trove of transfusion-related QA reports presented by General Counsel, only the 2012 “near miss” resulted in discipline. *Exhs. GC 8-14.* Considering the vastly different circumstances surrounding Catherine Ritchie, this example serves only to undermine

CMC's argument, particularly as Ms. Ritchie was terminated due to, *inter alia*, "signing excessive narcotics." *Tr. p. 2429*. Further still, despite her highly alarming infractions, CMC afforded Ms. Ritchie progressive discipline. *See Tr. pp. 2446-7*. In light of Ms. Ritchie's extreme transgressions, coupled with the uncertainty as to whether her complete file was produced, it is entirely unclear whether the near-miss was the actual reason for her departure. In any event, that Ms. Ritchie was terminated does not support the *bona fides* of the Marshall/Lamb firings.

C. CMC's Preferred Reasons For Discharge Are Pretext And/Or Substantially Unlawfully Motivated

The Board distinguishes between "pretext" and "dual motive" cases. *Wright Line*, 251 NLRB at 1084. Pretext is found where an employer's proffered legitimate business reasons are a "sham" in that they do not really exist or the employer did not rely on the proffered reasons. *Id.* at 1084. "Dual motive" or "mixed motive" exists where the employer relied on its proffered reasons, but also made its disciplinary decision in reaction to its employees' union activities. *Id.*

i. CMC Did Not Rely Upon The Alleged Policy Violations And Therefore Its Justifications For The Terminations Are Pretextual

If the evidence demonstrates an employer's "proffered lawful reason for the discharge did not exist, or was not, in fact relied upon," then the reason is pretextual. *LaGloria Oil and Gas Co.*, 337 NLRB 1120, 1124 (2002). Likewise, "[i]f no legitimate business justification for the discharge exists, there is no dual motive, only pretext." *Id.* (employees' driving performance was pretext for discharge, as no other employee had been discharged for similar driving infractions, discharge was made directly after employer became aware of protected activity, and prior

incidents were “dredged up” to mask discriminatory intent), citing *Talawanda Springs, Inc.*, 280 NLRB 1353, 1355 (1986). Hence, it follows that,

...a finding of pretext necessarily means that the reasons advanced by the employer either did not exist or were not in fact relied upon, thereby leaving intact the inference of wrongful motive established by the General Counsel.

Limestone Apparel Corp., 255 NLRB at 722, 736-37 (employees discharged in the middle of a rush order could not have been discharged for “lack of work,” as claimed by the employer.)

As discussed *supra*, in *Norton Audubon*, the employer’s proffered reason for the discharge of a nurse was found to be pretextual because the hospital had previously treated nurses guilty of much more egregious conduct more leniently, and because there was no clear policy forbidding the nurse’s action. 341 NLRB at 148, 152, 155. Likewise, pretext was found in *Affinity Medical Center* where, as discussed *supra*, a 23-year employee with no prior disciplines was discharged and reported to the state, ostensibly for neglecting a patient, when the timing of the disciplinary action was suspicious, the employer performed an inadequate investigation, and other employees with the same or worse violations were treated more leniently. 362 NLRB No. 78 at 1, n. 4 (April 30, 2015).

In *Nursing Center at Vineland*, a pro-union nurse was discharged for smoking at the nurse’s station; at the discharge meeting, a manager told the nurse that if the incident had happened a month earlier (before the union’s organizing campaign), she would not have been discharged. 314 NLRB at 951. The Board found, in light of the fact that the no-smoking rule had never been enforced previously and in fact smoking throughout the facility was common, the reassertion of the previously unenforced rule was pretext. *Id.* at 951, 953; *see also*, *Southside*

Hospital, 344 NLRB 634, 640 (2005) (negative change in duties of nutritionists based on pretextual motives when duties changed day after election, change attributed by management to union victory); *Golden State Food Corp.*, 340 NLRB at 383-85 (Board changed ALJ's mixed motive analysis to pretext analysis where employer stated on day of suspension, "we got him;" employer did not seek explanation from employee; and no other employees were disciplined for the same violation.)

Here, CMC's reasons for discharging Ms. Marshall and Ms. Lamb are patently pretextual. The Patient's complaint, which in its most embellished form was solicited by Ms. Raupers, enabled the Hospital to assert a pretextual basis for terminating Ms. Marshall and Ms. Lamb, while ignoring entirely her other concerns and complaints regarding the inconsistent use of neutropenic precautions, lack of green caps on lines, failure to call in an essential, post discharge script, etc. *See. Tr. pp. 880-1, 3392; Exhs. GC 18, E 6.*

The truth is that CMC's blood transfusion policy is by no means clear to the nurses.⁵¹ Dr. Daniel Sudilovsky, the policy's editor, went so far as calling the policy "an ongoing refinement" and a "living document." *Tr. p. 1872.* Quite telling is the fact that the policy was revised at least twice since the September 11, 2016 incident. *See Exhs. GC 60-1.* This policy applies to the entire Hospital, yet the daily circumstances within the ICU often make literal compliance impracticable, not to mention the policy's inconsistencies relative to the transfusion card, as acknowledged by no less than the policy's editor, Dr. Sudilovsky. Moreover, accessing the policy

⁵¹Even at trial, General Counsel and attorneys for both the Union and CMC were repeatedly confounded in obtaining a clear understanding as to various parts of the policy, particularly the two-tier, two-nurse verification concept.

is equally impracticable, considering nurses must first sift through over 100 distinct policies within CMC's intranet database. *Tr. p. 1157*. Adding a further hurdle, nurses are barred from printing the policy as they are subject to "day-to-day" change.

Understandably, ICU nurses relied often on their experience and training in navigating the blood-transfusion process. Thus, considering the policy's various impracticalities and inconsistencies, as well as the fact that no other nurse has been similarly disciplined for violations, particularly in light of the trove of transfusion-related QA reports, there was no clear standard forbidding Ms. Marshall and Ms. Lamb's actions.

ii. *To The Extent CMC Relied On Policy Violations, The Terminations Were The Result Of Mixed Motive*

Mixed motive is demonstrable through the circumstances surrounding the employer's actions, to wit: suspicious timing; more lenient penalties for neutral or anti-union employees who committed the same or worse violations; failure to consistently follow progressive discipline policies, to the extent they exist; failure to perform a good-faith investigation; taking unusually costly actions; and lack of harm to patients. *Greenbrier VMC, LLC*, 360 NLRB 994, 1001 (2014); *Addicts Rehabilitation Center Fund, Inc.*, 330 NLRB 733, 744 (2000); *Opportunity Homes, Inc.*, 315 NLRB 1210, 1219 (1994); *St. Margaret Mercy Healthcare Centers*, 350 NLRB 203, 204 (2007).

The failure to conduct a meaningful investigation or to give the employee subject to the investigation an opportunity to explain may constitute an indicia of discriminatory intent. *Diamond Electric Mfg.*, 346 NLRB 857, 860 (2006); *see also Amptech, Inc.*, 342 NLRB 1131, 1146 (2004) (failure to inquire of disciplined employee as to what occurred constituted a rush to

judgment attributable to respondent's unlawful motivation to take adverse action against the leading pro-union employee on the premises). Relatedly, an unexplained failure to abide by an employer's progressive discipline policy is a factor raising an inference of discriminatory treatment under the circumstances. *AdvoServ of New Jersey*, 363 NLRB No. 143, slip op. at 33 (2016).

In the matter at-bar, the Patient received the correct blood and suffered absolutely no harm.⁵² *Tr. p.3520*. It should be noted that at the 2016 hearing before ALJ Goldman, Interim ICU Director Crumb testified to the Hospital's general disciplinary practice, calling it a "progressive process," and that "[u]sually there's a verbal warning that can be presented in writing as a verbal warning; then a written warning; then suspension –and that can be various lengths of time– and then termination." *Goldman Dec.*, p. 43. Finding the implementation of this policy against Ms. Marshall in the earlier case to be unlawful, ALJ Goldman found that "Marshall's suspension ignored this 'usual' process" and that Crumb's investigation "did not involve getting Marshall's side [of the events]." *Goldman Dec.*, pp. 43-8. He determined Ms. Crumb's "findings" were "relied upon in a patently suspicious way," concluding "the weight of the evidence is that the results of [her] investigation were rigged." *Goldman Dec.*, p. 54. Similarly, in the instant matter, the terminations of Ms. Marshall and Ms. Lamb are highly suspect considering they had no previous disciplines, received no warning, and were treated much more harshly than other, former employees.

⁵²CMC's oft-repeated declarations of the horrifying and reckless nature of Ms. Marshall and Ms. Lamb's actions does nothing to change the fact that the right patient received the correct blood and there was, in fact, no genuine danger or risk.

Point II

CMC Violated the Act by Prohibiting Nurses from Posting Pro-Union Literature on the Bulletin Board

Employees have the presumptive right under §8(a)(1) of the Act to distribute union literature in non-patient areas. *St. Margaret Mercy Healthcare Centers*, 350 NLRB 203; *NLRB v. Baptist Hospital, Inc.*, 442 U.S. 773, 779-91 (1979). Moreover, it is unlawful discrimination without regard to the employer's motive, to prohibit posting union literature while permitting employees to post about nonunion activities. *Honeywell, Inc.*, 262 NLRB 1402 (1982) *enfd.* 722 F.2d 405 (8th Cir. 1983). In such circumstances, "an employer may not remove union notices." *Wal-Mart Stores*, 340 NLRB 703, 709 (2003).

This case is not the first instance in which CMC has unlawfully removed Union literature. *Goldman Dec.*, pp. 20-2. Indeed, this is not the first time Jackie Barr has unlawfully removed Union literature. *Goldman Dec.*, p. 21. Herein, Ms. Barr removed Ms. Marshall's postings from a CMC bulletin board regarding an upcoming Union organizing meeting. *Tr.* p. 1187. After removing the notice, she told Ms. Marshall that "the bulletin board is not for things like that." *Tr.* p. 1188. Yet clearly the board can be used for non-work related matters, such as the postings left on it for the Jehovah's Witness, salsa dancing and a lake swim. *Tr.* 1189. Based on CMC and Ms. Barr's history, apparently the bulletin board is welcome to anything but Union postings. *See Goldman Dec.*, pp. 20-2. Thus CMC violated §8(a)(1) of the Act when it removed the Union literature.

Point III

CMC Violated §8(A)(1) of the Act When it Questioned Potential Employee Witnesses

Pursuant to §8(a)(1) of the Act, employers must provide certain assurances against reprisals before interviewing employees about unfair labor practice charges. *Albertson's, LLC* 359 NLRB 1341, 1342 (2013); *Johnnie's Poultry*, 146 NLRB 770 (1964), enf. denied 344 F.2d 617 (8th Cir. 1965). To ensure employees are free from coercion, employers must: (1) convey to the employee, before the interview begins, the purpose of the questioning; (2) assure the employee that no reprisals will take place for refusing to answer any question or for the substance of any answer given; and (3) obtain the employee's participation in the interview on a voluntary basis. *Albertson's LLC*, 359 NLRB at 1342, citing *Johnnie's Poultry*, 146 NLRB at 775. Once the interview begins, the employer's questioning "must not be itself coercive in nature." *Id.*

Compliance with *Johnnie's Poultry* safeguards constitutes "the minimum required to dispel the potential for coercion" in cases where an employer questions employees in preparing for a Board Hearing. *Albertson's LLC*, 359 NLRB at 1343, citing *Standard-Coosa-Thatcher, Carpet Yarn Division*, 257 NLRB 304, 304 (1981), enf. 691 F.2d 1133 (4th Cir. 1982), cert. denied 460 U.S. 1083 (1983).

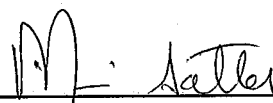
Herein Nathan Newman, a current CMC nurse, was provided no assurances that he would not face reprisals for refusing to participate in the Hospital's examination and questioning at trial. *See Tr. Pp. 2512-3*. In fact, Mr. Newman testified that he was not told specifically that his participation in the proceedings was voluntary. *Tr. p. 2514*. Thus CMC violated §8(a)(1) of the Act.

CONCLUSION

For the foregoing reasons, CMC violated §§8(a)(1) and (3) of the Act when it terminated Anne Marshall and Loran Lamb for engaging in protected, concerted activities; §8(a)(1) when it prohibited employees from posting pro-union literature while permitting other literature in a non-patient care area; and §8(a)(1) in the context of questioning an employee about possible testimony in this proceeding. Thus the terminated employees should be reinstated with full, make whole relief and protections against further reprisals; and other remedial steps and postings should be required, sufficient to insure employees are afforded their full, unfettered rights under the Act.

DATED: May 25, 2017

Respectfully submitted,



Mimi C. Satter, Esq.
Patrick R. Blood, Esq.
SATTER LAW FIRM, PLLC
Attorneys for Union
217 S. Salina Street, 6th Fl
Syracuse, NY 13202
Tel.: (315) 471-0405
Fax: (315) 471-7849